Arkansas Out-of-State Pharmacy Application

Completion of this application form is necessary for consideration for a permit to operate as an out of state pharmacy pursuant to Arkansas Pharmacy Law and Regulation. (You may download statutes and regulations from our website. The web address is: http://www.arkansas.gov/asbp/ Regulations for out of state pharmacies are contained in Regulation 4, beginning on page 16 of the regulation with 04-04-0001.) Disclosure of this information is voluntary. However, failure to disclose all requested information may result in this form not being processed and may subsequently result in denial of this application. All candidates for licensure, renewal, and/or examination have an obligation to update and supplement the information and responses on this application if they change. Failure to supplement the information and responses provided on this application may result in denial or other appropriate action. All information provided must be accurate. Please note that the information provided on this application is subject to the public information laws of this jurisdiction.

Carefully follow the directions on this application form. In addition, note the following:

1. Type or print legibly with black or blue ink only.
2. The registration and application fees are NOT refundable.

Please complete the entire application and submit additional pages as needed or as indicated in the instructions.

NOTE: Regulation 04-04-0001 (b) requires that: *A pharmacist licensed in Arkansas shall be named in the application as the pharmacy's pharmacist in charge for the Arkansas permit and as the contact person for communications by the Board.*
If your business does not currently employ an Arkansas pharmacist, one of your staff pharmacists will have to apply for licensure in Arkansas. This process usually takes some time if the pharmacist reciprocates through NABP. In addition, pharmacists applying for licensure by reciprocation must appear before the Arkansas State Board of Pharmacy and take the Arkansas Law exam. The Board meets the second Tuesday of February and October and at another date in June to approve reciprocating pharmacists. The fee for a permit is determined by the date your company *qualifies* for licensure and the permit is issued. For example, if your business applies for a permit to operate as an out of state pharmacy in Arkansas in September and you have no licensed Arkansas pharmacist employed, one of the pharmacists will need to apply for an Arkansas license. Though the Board meets in October, it is unlikely that your pharmacist will be able to reciprocate by then. Therefore, it will probably be February before your application is complete and your business qualifies for licensure. This will affect the amount of your application fee.

Out of state pharmacies are licensed for two year periods as follows: 2004-2005, 2006-2007, 2008-2009, etc. If you expect your application to be completed in an even-numbered year, the fee is $450.00; in an odd-numbered year, the fee is $300.00. If you have any questions about the fees or the application, please do not hesitate to contact us.

Supporting Documentation and Fees

Submit the following documents and fees:

1. This completed application (6 pages.)
2. A copy of your pharmacy license issued by the state in which the pharmacy is located.
3. A copy of your pharmacy's latest inspection report.
4. An application fee for an out of state pharmacy. See Part VII of the application.
5. Supplemental information as specified in the application.
6. A floor plan and description of your facility, if it is not a retail pharmacy.

Your application is NOT considered complete until all supporting documents and fees have been received by the Arkansas State Board of Pharmacy.

FOR OFFICE USE ONLY

License # _____

Date Issued: _____

Fee Submitted: _____

Application for a Permit to Operate as an Out-of-State Pharmacy in Arkansas

PART I: GENERAL INFORMATION					
1.	*Business Name*				
	dba				
2.	*Physical Address*				
	Street				
	City				
	State		*Zip*		
3.	*Mailing Address*				
	Street or PO Box				
	City				
	State		*Zip*		
	Telephone Number		*Fax Number*		
	Website				
4.	*Type of Pharmacy (check all that apply)*	___ Full line retail pharmacy ___ Internet pharmacy * ___ Clinic*		___ Specialty pharmacy* ___ Mail Order* ___ Other* *(please explain on separate sheet)*	
	Please provide a physical description and floorplan of your facility if it is **not a retail pharmacy.*				
5.	*Person with whom the Arkansas State Board of Pharmacy may communicate regarding this application:*				
	Name				
	Telephone		*Cell Phone*		
	Email				
6.	*Toll-free telephone number for Arkansas patients*			( )	
	How many hours per week is this line available?				
7.	*Hours of Operation*				
		Please express in terms of a.m. and p.m.		*Total Hours/Day*	
	Sunday				
	Monday				
	Tuesday				
	Wednesday				
	Thursday				
	Friday				
	Saturday				
			Total Hours per Week		
8.	Resident Agent - *please provide name, address, city, state, zip of Arkansas resident agent*				
9.	*Federal DEA Permit Number*				
10.	*Name of DEA Registrant*				
11.	*Has the applicant pharmacy ever been licensed in Arkansas?*			Yes [ ] No [ ]	
12.	*How long has the applicant been licensed as a pharmacy*			_____years	
13.	*Please list the states in which the applicant is licensed. You may attach another sheet if you need more space.*				

PART II: APPLICANT HISTORY

Please answer each of the following questions by putting a check (√) in the appropriate box on the right. You must answer each question with a "Yes" or "No" response as no other response is acceptable. All "Yes" answers MUST be explained in detail in a separate SIGNED and NOTARIZED affidavit. The affidavit should include all relevant dates, and identify the relevant jurisdiction and/or entity involved. Failure to disclose any of the requested information may result in the denial of your application or other appropriate action. NOTE: If you answer "Yes" to any of the questions below and you have already submitted a detailed affidavit to the Arkansas State Board of Pharmacy explaining your response you need not submit another detailed affidavit. Please note the date of your previous submission next to the applicable question(s).

14.	*Is the applicant currently under investigation in any state in which it is licensed?*	Yes [ ] No [ ]
15.	*Has your pharmacy ever been the subject of disciplinary action or been sanctioned by any licensing authority?*	Yes [ ] No [ ]
16.	*Has your pharmacy ever had a registration issued by a controlled substance authority revoked, suspended, surrendered, limited, or restricted?*	Yes [ ] No [ ]
17.	*Is their any disciplinary action pending against the pharmacy(applicant) by any licensing jurisdiction, the USDA, Drug Enforcement Agency, or any state drug enforcement authority?*	Yes [ ] No [ ]
18.	*Has your pharmacy every had any application for a license or permit refused or denied by any licensing authority?*	Yes [ ] No [ ]
19.	*Has the applicant ever been convicted of violating any federal, state or local law related to the practice of pharmacy?*	Yes [ ] No [ ]
20.	*Have any of the applicant owners, officers, directors, or stockholders ever been convicted of a felony or crime involving the practice of pharmacy? (If the business is a corporation, you need not include stockholders in this question unless they currently serve as officers or directors of the applicant business, or own more than twenty percent (20%) of the company stock.)*	Yes [ ] No [ ]
21.	*Has any sanction or disciplinary action been taken regarding any license, permit or registration issued to the applicant, officers, directors, partners or stockholders involving the practice of pharmacy? (If the business is a corporation, you need not include stockholders in this question unless they currently serve as officers or directors of the applicant business, or own more than twenty percent (20%) of the company stock.)*	Yes [ ] No [ ]
22.	*Are there any charges pending against the applicant, officers, directors, partners or stockholders involving the practice of pharmacy? (If the business is a corporation, you need not include stockholders in this question unless they currently serve as officers or directors of the applicant business, or own more than twenty percent (20%) of the company stock.)*	Yes [ ] No [ ]
23.	*Has the license or permit of the applicant ever been revoked, suspended or surrendered?*	Yes [ ] No [ ]

PART III: PERSONNEL					
24.	*List all individuals filling prescriptions or performing any function considered to be the practice of pharmacy for this business. You may attach additional sheets if needed*				
Name	**License #**	**Hours/Wk**	**Age**	**Degree**	**Hire Date**
Pharmacist in charge					
Arkansas pharmacist in charge* *For the Arkansas pharmacist, please provide the Arkansas pharmacist license number. If the pharmacist is reciprocating to Arkansas, please check one of the following months to indicate the expected appearance before the Arkansas Board. February____ June____ October____*					
Other pharmacists					
Interns	**License #**	**Hours/Wk**	**Hire Date**		
Pharmacy Technicians	**Registration #**		**Hire Date**		

**The Arkansas pharmacist in charge shall be an employee (not a consultant) of the applicant pharmacy who is present at the physical location stated on the application. The Arkansas pharmacist in charge need not be the same person as the pharmacist in charge of the pharmacy. The Arkansas pharmacist in charge is responsible for compliance with Arkansas regulations as they pertain to the shipment of drugs to Arkansas patients and for receiving and maintaining publications distributed by the Arkansas State Board of Pharmacy.*

PART IV: BUSINESS OWNERSHIP

25. Business Name:_____

Select the appropriate form of ownership from the choices below.

[ ] *Sole Proprietorship- Please provide the name and address of the owner.*

_____

_____

_____

[ ] *Partnership*

General Partnership – *please provide the names and addresses of all partners. You may attach a list of partners if there is not enough space.*

_____

_____

_____

_____

Limited Partnership – *please provide the names and addresses of all partners and indicate if they are general partners or limited partners. You may attach a list of partners if there is not enough space.*

_____

_____

_____

_____

[ ] *Corporation* [ ] Subchapter S Corporation

Employer Identification Number: _____

State of Incorporation _____

Is this corporation publicly traded? [ ] Yes [ ] No

Is this corporation a subsidiary of another company or corporation? [ ] Yes [ ] No

If yes, please explain your relationship to your parent company on a separate sheet or provide a schematic which illustrates the relationship.

President _____

Vice President _____

Secretary _____

Treasurer _____

Director _____

If you need additional space for the corporate officer list, please attach the list as a separate document.

[ ] *LLC Name:*_____

You may be contacted for additional information.

Officers

President _____

Vice President _____

Secretary _____

Treasurer _____

If you need additional space for the corporate officer/director list, please attach the list as a separate document.

(Continued on next page.)

LLC information, continued.
Name(s) of individual(s) who own more than twenty percent (20%) of the stock or voting rights of the company

[ ] *LLP Name:* _____
You may be contacted for additional information.

Please provide a general description of your company organization.

Please provide the names and addresses of all partners. You may attach a list of parnters if there is not enough space.

PART V: OPERATIONS

26. Please respond to the following statements/questions on the bottom of this sheet and the back of it. You can attach a separate sheet if you need more space to respond, or if you wish to use a computer to record and print your responses.

(A) Describe in detail how the pharmacy will comply with regulation 09-00-0001 – patient counseling, patient profile, drug use evaluation.
(B) Describe in detail how the pharmacy will ensure patient freedom of choice of providers.
(C) How do you plan to solicit business in Arkansas?
(D) Describe how the pharmacy will handle emergency prescriptions for patients in Arkansas. Include the name of the pharmacy located in Arkansas that will be contacted if an emergency occurs and your pharmacy cannot provide the medications in a timely way.
(E) How does your pharmacy ensure a valid patient/physician relationship?

PART VI: DOCUMENTATION

Attach copies of the following documents to this application:

(A) *A copy of the pharmacy license/permit issued by the state in which the pharmacy is located.*

(B) *A copy of the latest inspection report for the pharmacy issued by the regulatory agency that performs such inspections in the state in which the pharmacy is located.*

PART VII: APPLICATION FEE *Select one of the following.*

[ ] You have an Arkansas-licensed pharmacist on staff.
If yes, what is the date of this application?
Add thirty days. What is the new date?_____
If this date is an even numbered year, the fee is $450.00
If this date is an odd-numbered year, the fee is $300.00

[ ] One of your staff pharmacists will apply for an Arkansas pharmacist license.
Can he/she complete the reciprocation process by February, June or October?
Look at the February, June or October date.
If this date is an even numbered year, the fee is $450.00
If this date is an odd-numbered year, the fee is $300.00

[ ] This is a change of ownership. The fee is $150.00

PART VIII: CERTIFICATION *Please read carefully and sign below.*

I swear, or affirm that all statements made herein and on the attached forms are true and correct. All of the provisions of Arkansas laws and regulations related to the practice of pharmacy in Arkansas will be faithfully observed during the period any permit issued may be in force and effect.

I swear and affirm that I know where to locate the statutes and regulations related to the practice of pharmacy in Arkansas. (They are available online at the Arkansas State Board of Pharmacy website in the Pharmacy Lawbook section under the Pharmacy Practice Act § 17-92-101 *et seq* and Regulations 1 through 12.)

By virtue of filing this application, I do solemnly swear or affirm that I am of good moral character, and that I understand the instructions and terms as set forth in this application form, that I have personally completed this form, that the information given in this application is true, correct and complete to the best of my knowledge. I authorize the Arkansas State Board of Pharmacy to review files pertaining to this application and related documents, and all law enforcement records, administrative records, and court documents to confirm the accuracy and completeness of the information provided herein. This application and signature shall act as authorization for entities in possession of applicable information to release such information to the Arkansas State Board of Pharmacy.

Signature of Owners/Representative: _____

Print the name of the Owner/Representative: _____

Position :_____ Date:_____

Signature of Pharmacist in Charge: _____

Print the name of the Pharmacist in Charge: _____

Date:_____

Checks should be made payable to: *Arkansas State Board of Pharmacy.*

Return the completed application and all related documents and fees to: Arkansas State Board of Pharmacy, 101 East Capitol, Suite 218, Little Rock, AR 72201 Website: *http://www.arkansas.gov/asbp* Telephone: 501-682-0190